International Models of Psychiatric Emergency Care: The State of Qatar

23

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A variety of cultural, legal, and ethnic influences have led to an increase in mental health-related emergency department (ED) visits in Qatar. Patients who experience psychiatric emergencies often require resources not available at the general hospital, and require transfer to an appropriate psychiatric facility such as the emergency department of Hamad General Hospital (HGH), the only hospital that provides psychiatric services in the country. In May of 2014, Hamad General Hospital established the psychiatric emergency service (PES) as an innovative and pioneering psychiatric liaison service based in the ED of

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HGH. This chapter describes this model of psychiatric emergency services that successfully reduced response time, boarding time, and disposition when compared to previous years.

23.1 Introduction

Qatar is a Middle Eastern country with significant oil and natural gas reserves, located on a peninsula bordering the Persian Gulf and Saudi Arabia. Since 1995, there have been sweeping political reforms and unprecedented economic investment. A peaceful change of power in 2013 established a government that placed priority on improving the domestic welfare of Qataris. Changes included the establishment of advanced healthcare and education systems, and the expansion of the country's infrastructure. The majority of the 2.3 million inhabitants are clustered in and around the capital of Doha; however, only 10–12% of the inhabitants are Qatari nationals [1]. The remaining populace is comprised of members from at least 52 different ethnic backgrounds, and are known within Qatar as expats. The majority of the overall population are males between 18 and 45 years of age [1]. Approximately 68% of the populace practices Islam, while 14% are Christian and 14% are Buddhists. The primary languages are Arabic (official) and English [1]. The government is an absolute monarchy, with a mixed legal system of civil and Islamic law. Healthcare planning, infrastructure, and oversight in Qatar are under government control. The national health insurance, also under government control, provides free basic emergency and primary care coverage.

23.2 Emergency Psychiatry Service Structure

Hamad General Hospital's (HGH) emergency system is one of the busiest emergency services in the country. HGH logs around 1500 emergency department (ED) visits a day, or approximately, half a million visits per year. The annual number of visits to all emergency departments of Hamad Medical Corporation was 1.2 million in 2018 [2]. HGH has the only ED in the country that accepts psychiatric patients. Although psychiatric visits do not exceed 2–3% of all ED visits, an average of 20–30 psychiatric patients are seen approximately every 24 h [3].

Non-Qatari, or expat patients, generally come from low socioeconomic backgrounds and have little to no education; hail from a variety of different systems of beliefs, language, and customs; and hold differing beliefs and views of mental illness. Many suffer from the stressors of hard labor and crowded camps, which means that this population meets many of the risk factors that predispose individuals to the onset or exacerbation of new or pre-existing mental illness. Although Qatari nationals only constituted 10–12% of the population, they represented 42% of the patients

presenting to the emergency department (ED) [1]. This was due, at least in part, to increased mental illness secondary to genetic pool concentration; it is estimated that the marriage rate between first cousins (consanguinity) constitutes almost 54% of all marriages [4–6].

Because of the absence of community-based support institutions, including peer support groups and outreach programs in Qatar, and because the number of inpatient beds stayed the same for almost 35 years, it became clear that the healthcare system was facing a bottleneck problem when it came to admissions or outpatient referral for mental health issues. This reality dictated the need for a fast and intensive intervention, thus creating a "de facto" psychiatric intensive care unit (PICU) in the emergency room.

Initially, on the morning shift, the psychiatrist was part of the psychiatry department hosted by the ED, and on-call psychiatry residents covered the afternoon and night shifts, with telephone support from a psychiatrist or psychiatric consultant. A senior consultant psychiatrist, a staff psychiatrist, and a senior resident in psychiatry constituted the nucleus of the Emergency Psychiatric Service (EPS) team.

In 2014, a comprehensive psychiatric emergency service (PES) was established and became a core service of the ED similar to trauma, cardiology, toxicology, and surgery. The head of the PES was hired and employed by the ED as part of the ED faculty, was responsible for clinical work, and assisted in the development of clinical pathways, treatment protocols, and policies. In response to the Qatar National Mental Health Strategy 2013–2018 [7], a psychiatric emergency fellowship training program was created with three fellows accepted every year; the team also included two full-time psychiatric nurses and access to social services.

23.3 Emergency Psychiatry Service Systems Flow

Patients arrive at the ED from various sources as depicted in Table 23.1. As the result of a scarcity of psychiatric beds and obstacles to discharging patients, patients who need admission to the 67-bed psychiatric unit are initially kept in the ten-bed ED unit for psychiatric care, and are treated as if they are in an acute psychiatric care unit. There are also non-clinical factors that contribute to prolonged stays in the ED as described in Table 23.2.

On the patient's arrival, the ED psychiatrist serves as the attending of record, orders all necessary tests, consults with other disciplines as appropriate, and initiates treatment. The psychiatrist has scheduled rounds twice a day, titrates medications, and orders a sitter as needed; in short, they do everything that would be done on an inpatient unit. On numerous occasions, severely mentally ill patients are admitted to the inpatient psychiatric unit, but remain, and are treated for many days in the ED ("boarded"). Once stabilized, the patients are discharged and followed up with in the outpatient clinic within two working days of discharge.

Table 23.1 Referral sources for psychiatric evaluation in the emergency department

Source	Reason for referral	Comment
Field	Any culturally unacceptable behavior.	Most referrals display symptoms of heat exhaustion with confusion and disorientation.
Family	Threatening behavior toward family member(s).	Culture and traditional family structure has a high tolerance for a family member who suffers from mental illness.
Police	Homelessness, loitering, physical altercations, or threats	These behaviors are prohibited in Qatar, and police bring patients to the ED after being called by neighbors or family members.
Prosecutor	Personal claim or demonstrated evidence of mental illness for pretrial evaluation.	The forensic psychiatry service does not cooperate with the court system. Usually a court order mandates a 15-day hospitalization for observation and evaluation.
Correctional and Deportation Officials	Substance abuse, malingering, fights, suicidal gestures or attempts in the prison system or the deportation camps.	These are direct causes for bringing the involved individuals to the ED for psychiatric evaluation.
Airport	Any suspicious behavior, loudness, confusion, or disorientation.	These behaviors trigger the authorities to send the person to the ED for psychiatric evaluation.
Public and Private Hospitals	All suspected psychiatric patients are transferred to HGH for evaluation and management.	None of the eight general hospitals or numerous smaller private hospitals has a psychiatrist available in their ED.
Psychiatric Hospital Outpatient Clinic	The scarcity of psychiatric beds results in the outpatient clinic admitting to psychiatry through the ED.	The EPS provides intensive psychiatric treatment and management, often housing the patient in the ED until the patient improves and is discharged from the ED to follow-up with the outpatient clinic.

23.4 Patient and Staff Safety Concerns

In spite of improvements in care, the reality of utilizing the ED for inpatient style psychiatric treatment is not without unnecessary and increased risks for the psychiatric patients, other patients in the general population, and the ED staff [8, 9]. Psychiatric patients are seen in beds scattered across the entire emergency department, only separated based on gender and whether or not the patient is a Qatari national or foreigner. In addition, since all patients remain in street clothes, ED staff has difficulty locating them if they stray from their assigned bed. When boarded with the general ED patient population, several factors contribute to the substantial risk these patients present to themselves and others (see Table 23.3). Complications arise as staff may not receive training for interventions in cases of violent outbursts. As a result, there are numerous physical attacks on staff. Another consequence is that the mentally ill patient might abscond and pose a danger to themselves or others in the community.

Table 23.2 Non-clinical factors contributing to prolonged stays in the emergency department

Contributing factor	Comment
"Deliver and leave"	Some families bring the patient to the ED, then refuse to take him/her home and insist on a prolonged psychiatric admission regardless of the lack of clinical indication. The absence of social services and community safe housing renders it impossible to discharge such a patient.
"Sponsor" refused responsibility	Every non-Qatari national (expat) must have a local national who serves as a legal sponsor. Many times the sponsor refuses to assume the responsibility to accept a "mentally ill" employee back into his/her workforce. The only recourse is to refer the patient to the deportation authority, because without a sponsor, an expat becomes illegal in the country. That process may take many days while the patient is lingering on a cot in the ED.
Police too "busy"	Patients brought in by the police for a myriad of reasons have to remain in the ED until the police representative can pick up the patient, in most cases simply to release him/her on their own reconnaissance.
Wait for Embassy translator	Some patients are from an ethnicity that speak a rare language or dialect. Care is delayed until the appropriate embassy can send a translator.
Airline representative unavailable	Transit patients from the airport who are brought in for a mental status examination or psychiatric evaluation as a clearance for further travel are required to remain in the ED until an appropriate flight is scheduled or the representative has time to provide transportation back to the airport.

Table 23.3 Factors contributing to aggression in the emergency department

Factor	Comment
Lack of environmental control	The ED is divided into two general areas: The Qatari and the Non-Qatari areas; furthermore, each area is divided into female and male areas, with separate access doors, ambulance driveways, and waiting rooms.
Lack of differential clothing	Only unconscious or intubated patients are dressed in hospital gowns; the rest are in their street clothing, contributing to difficulties distinguishing patients from visitors or from some staff.
Unlimited visitation	No limit on the number of visitors or time of visit.
Lack of staff ability and/or willingness to restrain patients	Staff refuse to be trained in restraining, subduing, or stopping patients from leaving because the hospital refuses to provide legal immunity or insurance for any consequence.
Lack of authority of security personnel	Hospital security is present but has no authority to touch, restrain, or stop a patient from leaving.
1500 patient visits per day	Chaos and long waits are inevitable; combined with poor logistics and multiple linguistic barriers, the temper volatility is inevitable.

23.5 Personnel and Staffing: The Psychiatric Emergency Services Team

The Qatar National Mental Health Strategy 2013–2018 [7] provided funding for additional psychiatric training to meet the needs of the population. A psychiatric consultation liaison/emergency (CL & ED) fellowship training program began in September of 2014 with three fellows every year. Funding for this program covers

three fellows and invited faculty annually. The team also includes two full-time psychiatric nurses who are responsible to conduct triage, obtain patient history, and gather any pertinent collateral information. As a result of this program, by the end of 2015 the PES team grew to include two more psychiatric consultants, two psychiatric specialists, and two to four residents at all times.

23.6 Considerations of Coordination of Care

The team approach to patient management proved to be the most beneficial in improving outcome, decreasing the length of stay, and minimizing adverse reactions and medical mistakes. Every patient receives a complete history and physical upon registration, regardless of the primary complaint that brought them to the ED. Further medical investigation and consultation are dictated by the initial findings, age, medical history, and presenting complaints. Patients needing admission to an acute psychiatric bed, or an early outpatient appointment, are handled by the nursing staff who contacts the bed manager and/or the outpatient scheduler. Social services are helpful in establishing relationships with the authorities. Any contacts with the police, the court system, and the patient's legal guardians have to go through social services first. Doctors, nurses, and other staff members are not allowed to contact those entities independently. Since the psychiatric hospital is not part of the main campus of Hamad Medical City, patient transport is strictly done by ambulances that are well equipped [10], and their cooperation is swift and professional.

Under certain circumstances, care also needs to be coordinated with the hospital administration. For example, if a "VIP" (very important person) arrives to the ED for any reason, the staff is required to contact administration, who take over the room assignment, the food services, and name the doctor and staff members who will have contact with that VIP. Administration also decides when that person will be discharged from the ED and where they will go afterwards. Additionally, administration has to be involved whenever there is a potential conflict with a Qatari national in the ED.

Last but not least, care has to be coordinated with religious or traditional healers. Qatar is an Islamic State that follows a strict school of Islam. The belief that any mental illness is the Wrath of Allah, or a sign that the afflicted person is under an evil spell or possessed by Jinn, is well rooted in the population [11, 12]. Possession states can only be understood through a combination of biological, anthropological, sociological, psychopathological, and experimental perspectives. The patient's own interpretation of what is happening to them also has to be taken into consideration. Coordinating with religious or traditional healers promotes collaboration, even if it has little bearing on the treatment given.

23.7 Healthcare Funding and Resources

Qatar is a wealthy country that boasts the highest average individual income in the world at US$123,000 per year [13]. Healthcare expenditures represented 2.2% of the annual national budget in 2014 and did not change in the subsequent years; nor did the

share of the health budget designated for mental healthcare, which remained steady at 2%. The per capita general health expenditure stood at US$3071 per year, per person in 2014 as compared to US$9036 per capita for the same year in the USA [14].

The State of Qatar provides universal health insurance and access to more than 2.3 million residents, tourists, and transit passengers, regardless of their pathology, ability to pay, country of origin, mode of arrival, or legal status. This policy allows healthcare personnel and patients to take whatever medical measures are needed to best serve the patient without worrying about pre-authorizations, denials, or repercussions.

There is limited funding and resources for children with mental disabilities, cerebral palsy, and rare conditions; and for children diagnosed with autism and Down syndrome. Qatar has one central, special institute that provides limited outpatient services to a limited number of clients below the age of 18 [15]. Once these individuals reach the age of 18, they are not offered any services or support from the community or specialized centers such as daycare, rehabilitation centers, or vocational training. The ED is the only place to turn when an individual from this population becomes agitated, violent, or acts out. In the absence of community-based resources, the emergency room and the families of this population have a difficult time dealing with these patients.

Red tape and rigidity stand in the way of developing the mental health system at a faster pace despite the available funds and resources. For example, although there is a clear need for expansion and increased access to beds in psychiatric hospitals, any attempt to accelerate the process is met with resistance. The government's standard response is that it is part of the long-term strategy and cannot be changed before it's time.

23.8 Mental Health Legislation

Up until 2013 when Qatar's National Mental Health Strategy (NMHS) was introduced, Qatar operated without any mental health act; however, the government did recognize that the mental health needs of its population were inadequately addressed [7, 16, 17]. It was very difficult to hold or commit anyone, regardless of the risk they presented to themselves or others, or the severity of their mental illness, unless a police or prosecutor order was obtained to do so. The NMHS Act of 2013 was mostly a combination of the British Mental Health Act, with additions that conformed to, and incorporated, traditional and cultural aspects of the Qatari society.

Although the mental health act was updated, the penal code continues to reflect the criminalization of certain aspects of mental illness, including attempted suicide. That limitation makes it almost impossible for a patient who attempts suicide, or commits an intentional act of self-harm, to come forward and seek help for the injury itself, or for the underlying psychiatric disorder [18, 19]. Additionally, adultery, sexual assault, domestic violence, illegitimate pregnancy, and abortion are considered mandatory reportable felonies, and carry penalties of imprisonment and/or fines, with stiffer punishments levied on the treating physician if they fail to inform the relevant authorities [20–23]. Since every female of child bearing age who comes

to the ED is tested for pregnancy whether she agrees to the test or not, many patients refrain from seeking help for any reason, not only for psychiatric problems [24]. It is difficult to estimate the psychological harm that is imposed by this significant barrier to accessing care.

In a very religious, Muslim country like Qatar, alcohol is prohibited, and only certain foreigners may buy it from a government-run dispensary; and only after undergoing a strict vetting process for religious affiliation and income level. The individual also needs a license to buy alcohol, which is a government issued special ID card. The amount of alcohol that such a license-holder is allowed to buy cannot exceed a certain percentage of their monthly income [25, 26]. As a result, most alcohol abusers are closet drinkers and rarely come forward to seek treatment; therefore, most of the cases that present to the ED are patients who are severely intoxicated, in a state of severe withdrawal, or display signs of Wernicke's. The same is true of hardcore opiate and other drug abusers. Treatment is offered for withdrawal, but there is no long-term treatment option, or appropriate and adequate follow-up, leading to a revolving door in the ED.

23.9 Education

Medical schools in the majority of the Middle Eastern countries involve a 6-year program immediately after high school, and psychiatry is not part of a student clerkship. The psychiatry residency in Qatar is a separate, 4-year ACGME-I accredited program, and is affiliated with Weill-Cornell Medical College-Qatar. The newly established psychiatric emergency services have opened multiple venues to educate, treat patients, and perform research.

The Fellowship in Emergency Psychiatry training program attracts many senior residents from the local residency program, as well as from other countries, including Saudi Arabia and Spain. The fellowship lasts for 3 years, and combines education, research, and service with an end-goal of independent practice as a consultant in Consult Liaison and Emergency Psychiatry. In addition, emergency room physicians must attend three psychiatric continuing medical education (CME) modules on suicide screening, delirium screening, and the BETA project (Best Practices in Evaluation and Treatment of Agitation) [27]. The senior consultant psychiatrist is responsible for developing the curriculum for the ED residents' psychiatry rotation, and participates in at least three educational modules per year for the ED attending physicians. Daily CL & ED didactic and case presentations are open to all practitioners.

23.10 Quality Initiatives and Quality Assurance

All residents, fellows, and attending physicians must complete research training (Collaborative Institutional Training Initiative). Research and clinical improvement projects have streamlined therapeutic approaches that include treatment algorithms and operational policies. The hospital collects detailed information from each

patient that includes the time of patient arrival and discharge, demographics, length of treatment, mode of arrival, use of physical restraints, rates of absconding, and falls. For patients who regularly utilize emergency treatment, the frequency of their ED visits and drug-seeking behaviors lead to specific treatment plans.

The newly-developed PES service in a Qatar's major general hospital achieved rapid improvements in care. In less than 2 years after publication, the Best Evidence Based Treatment of Agitation (BETA) became a national clinical policy to manage agitation in the State of Qatar [27, 28]. Alcohol withdrawal was standardized with two pathways: The CIWA pathway and the Lorazepam fixed dose pathway [29, 30]. Screening for delirium using the Stanford Proxy Test for Delirium (SPTD) [31] increased the clinical diagnosis of delirium from 5.3% to 19.55% of all admissions, which resulted in improvements in care [32].

After the PES became fully functional, disposition, defined as the time from registration to the time of the clinical decision regarding the post-ED care, was the single most improved domain in patient care. The wait time to be seen, evaluated, diagnosed, and disposition made, improved 37-fold [33]. A thorough evaluation, combined with a bedside psychotherapeutic intervention, suitable psychopharmacology, and the provision of a follow-up appointment, decreased the total number of psychiatric admissions by 18% [33].

23.11 Summary

The introduction of the psychiatric emergency services program in the nation-state of Qatar, coupled with the continual improvement process in refining this program, has resulted in a safer and more effective treatment model for the mentally ill within its borders. Although the program is still relatively new, this is a promising indication that the PES, as part of the global healthcare improvement and expansion of logistics in the State of Qatar, is poised to continue to provide better, more efficient, and safer treatments for the mentally ill in the ED of the hospitals in Qatar.

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